New Hampshire

Onychomycosis Agents

NH Medicaid Prior Authorization/Non-Preferred Drug Approval Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

First Health Services

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___

SECTION I: Patient Information and Medication Requested

Name: (Last, First) _____ NH Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name: _____ Strength: _____

Dosing Directions:_____ Length of Therapy: _____

SECTION II: Clinical History

1. Patient's diagnosis: _____
2. Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication (immunosuppression, diabetes, peripheral vascular compromise): _____
3. List pertinent laboratory test(s) or procedure(s) if applicable: KOH, PAS, Culture, etc.

Procedure	Findings	Date
_____	_____	_____
_____	_____	_____

4. Is the patient experiencing pain which limits normal activity? ☐ Yes ☐ No
5. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

_____

_____

_____

If you are requesting a non-preferred product, proceed to Section III. If not, then proceed to Section IV.

SECTION III: Non-Preferred Drug Approval Criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria:

☐ Allergic reaction ☐ Drug-to-drug interaction. Please describe reaction: _____

☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____

_____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information: _____

_____

☐ Age specific indications. Please give patient age and explain. _____

_____

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference. _____

_____

☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

_____

SECTION IV: Prescriber Information

Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Signature of Prescribing Provider